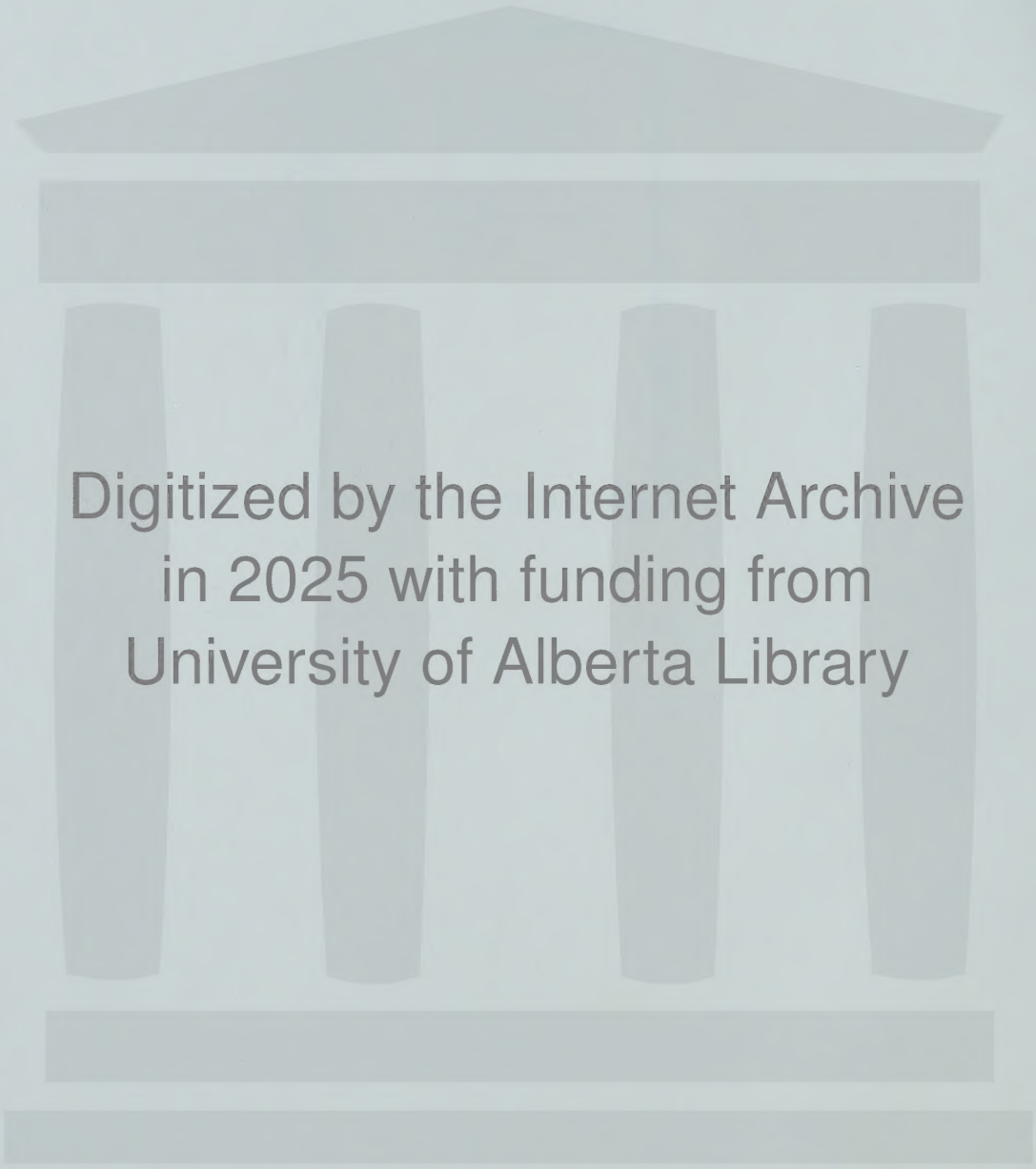

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Graduate Training Needs in Sexual Counselling

by

Kirsten Anne Jordan 

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Education

in

Counselling Psychology

Department of Educational Psychology

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University of Alberta

Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommended to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled Graduate Training Needs in Sexual Counselling submitted by Kirsten Anne Jordan in partial fulfillment of the requirements for the degree of Master of Education in Counselling Psychology.

Abstract

The purpose of this research is to illustrate the training needs of counselling psychology graduate students in sexual counselling. Variables investigated included student comfort with sexual counselling, knowledge of human sexuality, sexual counselling interview behaviors, level of erotophilia, previous education, and desire for more training. The degree that students felt supported by instructors and supervisors in the area of sexual counselling was also queried.

Of the 36 graduate students who completed the survey, two-thirds initiated questions about sexual concerns with less than ten percent of their clients. Statistically significant positive relationships were found between sexual counselling comfort and counselling experience, sexual counselling comfort and prior reading about sexuality, erotophilia and counselling experience, and erotophilia and sexuality knowledge. Many students reported a perceived lack of support from instructors and supervisors in the area of sexual counselling. All (100%) of respondents wanted more sexual counselling training available in their graduate programs.

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Table of Contents

List of Tables

Chapter 1 – Introduction

Researcher Background

Interest in providing interventions for people with sexual health concerns developed during my occupational therapy student training. The school that I attended had integrated sexual health curriculum and guest speakers into several courses. For example, one guest lecturer spoke of sexual dysfunctions as they relate to spinal cord injury during a course in neuroanatomy. Sexual health clinicians also came to teach about basic counselling skills necessary when discussing sexual concerns with clients. This occurred during a course about the psychosocial aspects of disability. Discussions about sexual activity as it relates to the theoretical models of occupational therapy also occurred during theory courses. Occupational therapists assist people with their ability to function during their activities of daily living, of which sexual activity is a part. Thus, this training gave the message that sexual health was an important part of overall health, and that I had a role in facilitating the resolution of sexual health concerns together with my clients.

Opportunities to practice basic communication skills regarding sexual difficulties with clients occurred during my occupational therapy student practicums. During my first practicum, I spoke with men and women post-surgical-hip replacement, as they lay in their hospital beds, about everything from raised toilet seats and bathing to safe sexual positioning. They were offered a handout that diagramed several positions for intercourse that would prevent hip dislocation after surgery. Speaking to 70 to 90-year-olds regarding sexual positioning challenged biases and assumptions about the sexuality of elderly individuals. Talking about sex, even in this brief and fairly superficial way, was difficult. Masking my own discomfort in order to enhance the comfort of clients was challenging, but became much easier with practice. Then, during subsequent practicums, I found myself initiating discussions about sexual concerns with clients, even when my supervisors were not. In every case, clients were not offended. Many were often relieved that someone had asked them about a topic that they were having difficulty discussing. I began to believe that therapist discomfort with this area was a barrier to sexual health, and that I had something to offer.

Upon graduation, I worked for two years as an occupational therapist with injured men and women who had chronic pain. With this population of clients, sexual dysfunction was complex, not simply related to physical limitations. Clients were struggling with the impact of job loss, depression, relationship stressors, pain, sleep deprivation, anxiety and medication side effects. Each of these factors contributed to and was affected by sexual dysfunction. A man with a lower-back injury might be told by his urologist that his erectile dysfunction was "non-organic," meaning that there was no biological explanation for his problem. It became apparent that such clients required individual and/or couples counselling to address the psychological components of their sexual problems. The question then became – to whom should we refer? Aware of the need for counselling psychologists trained in the area of sexual counselling, I entered my master's of education program in counselling psychology.

Statement of the Problem

Awareness of the need for more graduate-level training devoted to the area of sexual counselling came from personal experience. Counselling clients with sexual dysfunctions was not a topic that was addressed during my graduate coursework or practicums. I felt as though I was not encouraged to include this area of individual health in client interviews, and began asking my clients less about sexually related concerns. I realized that it was difficult for instructors to address the multitude of possible counselling topics with limited time and resources. However, from past experience, I believed that the skills required for sexual counselling were not easily generalized from other counselling skill-sets, that students required explicit information, encouragement and practice of such skills in order to be prepared to meet clients' needs. I noticed the discrepancy between the amount of training that occupational and physical therapists received and the training of counselling psychologists in basic approaches to sexual counselling, and believed that counselling psychologists should be prepared as least as thoroughly as such health professionals. These beliefs led to a literature review regarding the need for sexual counselling amongst clients as well as the status of graduate-level training in counselling sexual issues.

The prevalence of sexual dysfunction in the population is high. According to a national sample from the United States, approximately 43% of women and 31% of men report sexual difficulties (Laumann, Paik, & Rosen, 1999). Not only is sexual dysfunction common, it is also significantly related to quality of life indicators such as relationship satisfaction and happiness (Morokoff & Gillilland,1993; Perlman & Abramson, 1982). Sexual problems are also more likely to occur with individuals who are experiencing psychosocial concerns such as depression or anxiety (Laumann, Paik, & Rosen, 1999) or being medically treated for such concerns (Balon, Yeragani, Pohl & Ramesh, 1993). Despite personal sexuality concerns, clients may be remise to discuss them with their therapist due to social taboos, fear of embarrassment, or lack of the education, vocabulary and practice required for talking about sex. Given the identified needs of clients and barriers to accessing help, it is imperative that counselling psychologists take the initiative to inquire about sexual health with their clients.

However, the majority of graduate-level training programs in counselling psychology include either inconsistent or inadequate training regarding sexual counselling (Freeman, 1989; Gray, Cummins, Johnson, & Mason, 1989; Nathan, 1986; Wiederman & Sansone, 1999). In two surveys of the training directors from American Psychological Association-accredited doctoral programs, it was found that 22 to 38% of programs involved no course-content related either to human sexuality or to sex therapy (Nathan, 1986; Wiederman & Sansone, 1999). Programs with sexuality-related courses tended to be larger with as least one faculty member who had a strong research or practice interest in sexuality. Clearly, curriculum needs to be either improved or newly developed in many counselling psychology training programs. In order to make such improvements, it is important to also understand the educational needs of graduate students regarding sexual counselling, from the student's perspective. The researcher found no research regarding the needs of graduate students from their perspective. The

problem, as outlined above and further delineated in subsequent chapters, led to several research questions regarding the educational needs of psychologists-in-training with respect to sexual counselling.

Research Questions

The focus of this research was to gain information regarding the answers to the following questions:

1. How comfortable do graduate students feel about discussing sexual issues with their clients?

2. How knowledgeable are graduate students in various topics of human sexuality?

3. How often are graduate-student counselors asking their clients about whether or not they have sexual concerns?

4. To what extent do graduate students desire more training related to counselling sexual issues? What form of training is preferred?

5. How erotophilic / erotophobic are graduate students in counselling psychology?

6. How much general counselling and sex-related counselling experience do graduate students have?

7. How much course-work or reading have graduate students completed with respect to human sexuality-related topics?

8. Are there any significant correlations amongst the concepts investigated in the questions above (comfort, knowledge, desire for training, erotophilia, and experience)?

9. During their graduate training, what level of support and kind of messages have graduate students perceived from interactions with instructors and supervisors, with respect to sexual counselling?

Given that no prior research was found regarding such characteristics of psychologists-in-training, no predictions or hypothesis were made about the results. Thus, research questions were descriptive in nature.

Sample and Instrument

A convenience sample of the 64 students in a graduate-level counselling program from one Canadian University was surveyed. A total of 36 students responded to the questionnaire that was distributed. The researcher chose to limit the study to currently enrolled graduate students from one university, due to time and financial restrictions.

Participants were surveyed with a questionnaire entitled the "Sexual Counselling Survey" (see Appendix for a copy of this instrument). The researcher developed this questionnaire after consideration of personal training and counselling experiences, and after consultation with university educators knowledgeable in the area of sexual health education. Questions were divided into sections that were designed to provide information regarding a number of constructs, including comfort with sexual counselling situations, knowledge of human sexuality, erotophobia / erotophilia, interview behavior regarding sexual issues, past counselling experience and desire for graduate-level education in sexual counselling. Questions were also included regarding the messages and level of support that students received during their graduate training regarding counselling sexual issues.

Overview of Chapters

This thesis contains five chapters: an introductory chapter (Chapter 1), three chapters (Chapters 2 to 4) that are each individually publishable, and a summary chapter (Chapter 5). The three-paper format for this thesis was chosen as it was most in-keeping with the three-fold intent of the research, to 1) provide counselling instructors with the information needed to promote, develop or improve sexual counselling curriculum, 2) increase awareness of the problem of counsellor-preparation in the area of sexual counselling, in order to decrease risks to clients, and 3) encourage the general public to be proactive in accessing assistance with sexual health concerns. Writing the thesis in this format was seen as the most efficient route to effecting change and disseminating information in the form of publications. One paper of the three papers was written for a popular magazine such that this research would not only reach the academic community but would also benefit a large number of people in the general public.

Chapter 1 includes some background on the researcher and a statement of the research problem. In Chapter 2 or Paper #1, graduate student characteristics such as comfort with sexual counselling scenarios, knowledge of human sexuality, and desire for sexual counselling education are described. Recommended guidelines for curriculum development are included in this paper, and thus it will be submitted to academic journals of interest to counselling instructors and supervisors. In Paper #2 (Chapter 3), the discrepancy between the prevalence of sexual dysfunction and the degree that graduate students are prepared to discuss sexual issues with their clients is emphasized. Suggestions are made in this paper to protect against the risk of poor service for clients, and it will be submitted to academic human sexuality or sexual counselling journals. Chapter 4 or Paper #3 was written for a non-academic publication in a magazine with a wide readership. In this paper, literature is reviewed to normalize sexual dysfunction amongst individuals and couples, and to encourage people to be proactive with their physicians or counsellors in order to access the assistance that they may require. In the final chapter, results related to the initial research questions are summarized and limitations of the study are detailed, with recommendations for future research.

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Chapter 2

Paper #1: Sexual Counseling Training: Exploring and Addressing the Needs of Graduate Students Counselors

The inconsistent and inadequate provision of education related to human sexuality for graduate-level counselling students is well-documented (Freeman, 1989; Gray, Cummins, Johnson, & Mason, 1989; Nathan, 1986; Wiederman & Sansone, 1999). The course offerings of departments and the opinions of faculty members has been the focus in these previous studies. Often, curriculum lacks content both in general human sexuality knowledge and in the introduction of sexual counselling skills. Without proper training, counselling departments run the risk of graduating psychologists who are poorly prepared to meet the needs of clients with sexual issues. The current study is focused upon the comfort, skills and knowledge of graduate students and their perceptions of how to meet their educational needs with respect to sexual counselling. No research has been found in which the need for training in sexual counselling, from the perspective of graduate students, is explored. It would be difficult to implement changes to old curriculum or develop new curriculum without knowledge about students' educational needs, desires and preferences.

Wiederman and Sansone (1999) conducted a survey of the training directors from all American Psychological Association (APA) accredited doctoral programs and APA-accredited predoctoral internship sites in North America. This survey contained questions regarding the sexuality-related content offered to trainees. Of the 95 doctoral programs surveyed, 31.6% offered no course content related to sex therapy, and 37.9% offered no course content related to typical or healthy sexual functioning. Similar results have been reported in earlier research. For example, Nathan (1986), who surveyed the directors of all APA-approved clinical psychology doctoral programs in the United States and Canada, found that 22% of respondents reported that their program included no courses that had even a small portion of sexuality-related content. Programs that include courses in sexuality tend to be larger, with at least one faculty member who has a strong research interest or teaching interest in sexuality (Nathan, 1986; Wiederman & Sansone, 1999).

It is difficult to draw conclusions about the status of sexual counselling education and programming, without information from the graduate student's perspective. Little is known about the knowledge, behaviors, comfort and experiences of graduate student counsellors with respect to sexual counselling. In contrast, substantial research has been conducted regarding the knowledge, attitudes and training needs of medical and allied health professionals in the area of addressing sexual issues with clients (Chan, 1990; Duldt & Pokorny, 1999; Fisher et al., 1988; Goldstein-Lohman & Aitken, 1995; Hay et al., 1996; Leiblum, 1995; Stayton, 1978; Tepper, 1997). The purpose of the current study was to illustrate the training needs of graduate-level student counsellors in the area of sexual counselling.

Method

This study was designed to explore and describe a number of graduate-level student characteristics deemed relevant to the area of sexual counselling by administering a questionnaire that was developed from a quantitative perspective. The quantitative variables investigated were student comfort with sexual counselling, knowledge of human sexuality, sexual counselling interview behaviors, level of erotophilia / erotophobia, and degree of counselling experience. Open-ended questions were used to explore the degree to which students felt supported and the messages they received during their graduate training regarding counselling.

Participants

A convenience sample of the 64 students (50 females and 14 males) in a graduate-level counselling program from one Canadian university was surveyed. A total of 36 students responded to the questionnaire that was distributed, an overall response rate of 56% (a gift certificate for a free specialty coffee had been included with every questionnaire. This gesture may have enhanced the response rate). Of these respondents, 15 were master's students, 20 were doctoral students and 1 student did not indicate his or her program level. There were 28 females, 7 males, and 1 student who did not indicate his or her gender. The proportions of males and females that responded to the questionnaire closely mirrored the proportion of males and females enrolled in the program. The researcher chose to limit the study to currently enrolled graduate students from one university, due to time and financial restrictions.

Measures

Participants were surveyed with a questionnaire entitled the "Sexual Counselling Survey." This questionnaire included questions divided into sections that were designed to provide information regarding a number of constructs, including comfort with sexual counselling situations, knowledge of human sexuality, erotophobia / erotophilia, interview behavior regarding sexual issues, past counselling experience and desire for graduate-level education in sexual counselling. Questions were also included regarding the messages and level of support that students received during their graduate training regarding counselling sexual issues.

Comfort in sexual counselling situations. Participant's degree of comfort with eight specific sexual counselling situations was elicited using five-point Likert scale questions. The sexual counselling scenarios were created by the researcher. An example of one such scenario is as follows: "On their third session of couple's counselling, a couple reveals that the man is experiencing erectile dysfunction and the woman is experiencing low sexual desire. How comfortable do you feel counselling them about their sexual relationship?" Participants indicated on a scale from one to five their degree of comfort, where one represented being very uncomfortable and five represented being very comfortable. The internal consistency for this measure based on results from this study was found to be ($\alpha = 0.89$).

Knowledge of human sexuality. The researchers created a 20-item multiple-choice test of human sexuality knowledge by selecting relevant items from two undergraduate human sexuality textbook test-banks (Kelly, 1990; Rathus, Nevid & Fichner-Rathus, 1999). These items covered a variety of topics including childhood sexual behavior, masturbation, disability, homosexuality, unwanted sexual contact, sexual dysfunction, sex therapy techniques, and HIV / AIDS. Item analysis using the Lertap 5 software program (Nelson, 2000) identified three items with poor discrimination and internal consistency values. These three items were eliminated and analyses were conducted using the revised 17-item total scores. Cronbach's alpha for the revised test was 0.50. The researcher did not expect internal consistency to be high, given the diversity of subject categories included in this test.

Interview behavior. One multiple-choice question was included to determine the frequency with which participants were asking their clients about sexual concerns. Students were asked the question: "During initial counselling interview(s), with approximately what percentage of your clients do you initiate questions about whether or not they have any sexual concerns?" and instructed to select one of five options.

Erotophobia / erotophilia. The Sexual Opinion Survey (Fischer, 1998) or S.O.S. was included in the questionnaire. It contained 21 seven-point Likert scale items (strongly agree to strongly disagree) designed to operationalize the degree to which a person is erotophilic or erotophobic. Fischer described that "the personality dimension of erotophobia-erotophilia is conceptualized as the learned disposition to respond to sexual stimuli with negative-to-positive affect and evaluations and is believed to determine avoidance or approach responses to sexual stimuli" (p.218). Scores on this survey could range from 0 (most erotophobic) to 126 (most erotophilic). Previous research had found Cronbach's alpha coefficient of internal consistency to be in the .82 to .90 range (Fischer, Byrne, White & Kelley, 1998) for samples of undergraduate student's. For the sample of graduate students in this current study, item responses indicated a Cronbach's alpha of .82.

Past experience, desired education and qualitative messages from program. A number of other questions were included to determine graduate student desire for education / training in the area of sexual counselling, form of education preferred, degree of past counselling experience, and amount of prior coursework, continuing education and reading related to human sexuality. Open-ended questions were placed at the end of the questionnaire where participants were encouraged to comment on the support and the messages they received from their instructors or supervisors regarding sexual counselling issues.

Procedure

Participants received their Sexual Counselling Survey either in their school mailboxes, during their classes, or in the local mail. They completed each questionnaire voluntarily, anonymously and independently, and returned these to sealed boxes or via mail. Participants required approximately 25 minutes to complete the questionnaire. They were encouraged not to answer any questions, including demographic ones, with which

they were uncomfortable and were informed that results, if published, would appear either in group form or as unidentified quotations. A follow-up electronic mail message was sent to all students as a reminder to complete the questionnaire.

Results

Comfort with Sexual Counselling Scenarios and Relationship with Counselling Experience

With the eight sexual counselling scenarios included in the comfort scale, student responses ranged from very uncomfortable to very comfortable. Their mean comfort scores, in order of decreasing levels of comfort, are presented in Table 2-1. Also presented in Table 2-1 is the percentage of graduate students who indicated that they were either very or somewhat uncomfortable with each scenario; these numbers ranged from 22.2% to 55.6%, depending on the scenario. To test for significant difference between mean comfort scores, the eight scenarios were divided into two groups: 1) scenarios familiar to participants (heterosexual and adolescent scenarios) and 2) scenarios unfamiliar to participants (homosexual, disabled and geriatric scenarios). The mean comfort score for the group one scenarios (Mean = 14.53, SD = 3.77) was significantly higher than the mean comfort scores for group two scenarios (Mean = 12.28, SD = 4.07), as indicated by a paired sample t-test ($t = 6.22$, $p < .001$). These results suggest that students were least comfortable with scenarios involving the sexual issues of people from minority groups such as those who are homosexual, disabled or elderly.

There was also a significant, moderate and positive correlation between the total number of hours that graduate students had spent counselling clients, and their comfort scores with sexual counselling scenarios ($r = .53$, $p = .001$). When participants imagined responding to the various sexual counselling scenarios, feeling less comfortable was associated with lower levels of counselling experience.

The Relationship Between Reading, Knowledge and Comfort

Those students who reported having read material to enhance their knowledge of human sexuality related topics (n=23) had significantly higher knowledge scores and significantly higher comfort scores than those who had not done such reading (n=13). Mean knowledge scores for these two groups were 13.48 and 11.81 respectively, while mean comfort scores were 28.78 and 23.31 respectively. One-way-ANOVA showed a statistically significant difference between knowledge score means, $F(1, 34) = 4.85$, $p = .035$, and between comfort score means, $F(1,34) = 4.86$, $p = .034$.

Sexual Interviewing Behaviors of Students

Of the 35 students who responded to the question regarding sexual interviewing behavior, 23 or 66% initiated questions regarding sexual concerns "With less than 10% of my clients." When comparing master's and doctoral students, 80% of master's students versus 55% of doctoral students initiated questions regarding sexual concerns "With less than 10% of my clients." Responses were skewed towards not asking clients about sexual concerns (see Table 2-2).

Erotophilia and Relationship to Counselling Experience and Knowledge

For female respondents (n = 28), scores ranged from 40 to 113, Mean = 83.93, SD = 15.03. For male respondents (n = 7), scores ranged from 86 to 111, Mean = 97.57, SD = 8.98. Prior normative research (Fisher et al., 1988)) on two female groups, volunteers for sex research from introductory psychology classes at an Ontario University and Canadian undergraduate students in a sexuality course, found that mean S.O.S. scores were 71.81, SD = 16.04, and 67.11, SD = 18.59 respectively. Using the one-sample t-test method, the mean S.O.S. score for female graduate counseling students in this study was significantly higher than the two aforementioned normative comparison groups ($t = 4.27$, $p < .01$, and $t = 5.92$, $p < .01$ respectively).

Total scores on the S.O.S. were correlated with counselling experience and knowledge of human sexuality. A significant, moderate and positive correlation was found between participants' (n = 33) total hours of counselling experience and their total S.O.S. score ($r = .38$, $p < .05$). The more hours students had spent counselling, the higher their S.O.S. score or erotophilia. Also, for the female participants (n = 28), total knowledge scores were significantly correlated with total S.O.S. scores ($r = .48$, $p < .05$).

Desire for Sexual Counselling Education

Of all the participants (n=36), 100% indicated that they would like their graduate program to offer more education / training in the area of sexual counselling. Participants were also asked to indicate in what form(s) they preferred such education to take place. A summary of responses is presented in Table 2-3. Fifty percent of all participants endorsed integrating material into courses via lectures and / or role-plays, 58% endorsed an optional three-credit course, and 44% endorsed an optional three-day training workshop.

Responses to Open-Ended Questions

Perceived support from instructors. Students were asked to respond to the question "Tell me the degree to which you have felt supported or encouraged by instructors or supervisors in the area of counselling sexual issues." Of the respondents (n = 33), 22 (67%) reported they had experienced little or no support. Three examples of typical written comments are listed below:

Zero;

Very little – the issue seems to be avoided; and

I feel instructors and supervisors are often uncomfortable with sexual issues in counselling, so tend to avoid it. Discussions regarding sexual issues are often pretty short.

Type of messages received from program. Students were also asked to respond to the question "Comment on the message(s) you have received from your graduate program regarding the counselling of sexual issues." Three examples of some of these written comments are listed below:

If not for the direct questioning from fellow students I don't believe it would have been addressed at all;

It's never come up – so I guess that's a message in itself. I think the graduate program is a reflection of the societal attitude towards sexual issues, which is if we ignore it we won't have to deal with it. I don't think this is a conscious decision; and

3) The silence around counselling sexual issues suggests that it's not important.

Of the respondents (n = 27), 24 (89%) reported they had received no messages, messages of "silence," or messages that this area of counselling was less important.

Discussion

There are several implications for the results of this research. It is hoped that awareness of the need for programming changes at the graduate level will increase, graduate training curriculum related to sexual counselling will be developed or enhanced, entry-level competency of counselling psychologists will be improved, and risks of poor service for clients with sexual concerns will be diminished. When drawing conclusions and suggesting implications, it is important to remain aware of the limitations of this study.

One must exercise caution regarding the generalizability of findings. Ideally, the target population for research implications would include all graduate-level counselling psychology students either nationally or internationally. However, a small convenience sample of students from one Canadian University, with limited male subjects, was studied. It would be useful for future research to expand on this study, with a larger, randomized sample taken from multiple training sites at the national or international level. If this study were repeated in the future, it would be useful to include questions of graduate students not only about their desire for more graduate training with respect to sexual counselling, but also about the content areas in which they are most interested in learning or feel most deficient.

Need for Curriculum Changes

The need for improved sexual counselling curriculum is recognized in the literature (Freeman, 1989; Gray et al., 1989; Nathan, 1986; Wiederman & Sansone, 1999). Results of this study illustrate this need from the student's perspective. Of the graduate students responding to the survey, 100% wanted more education / training in the area of sexual counselling to be included in their graduate program. Based on this unanimous result, students may not feel adequately prepared to meet the needs of their clients. Also, some students, particularly those with less counselling experience, do not feel comfortable when they imagine various sexual counselling scenarios. Their mean comfort scores were lowest for scenarios involving minority groups, an indication of the need for training that emphasizes the sexual needs and sexual practices of diverse populations. Nathan (1986) identified four levels of potential expertise in the area of sexuality-related counseling:

Level 1: Ability to be comfortable hearing and eliciting sexual material…

Level 2: Ability to assess the diagnostic significance of sexual behaviors and symptoms...

Level 3: Ability to evaluate sexual problems in order to intervene or refer…

Level 4: Ability to treat sexual problems and/or to teach and do research in the field. (p. 521).

She suggested that at least level one, comfort with discussing sexual issues, should be attained prior to graduation, and that exposure to training at levels two and three often results in improved comfort at level one.

Researchers have documented the high prevalence of sexual dysfunction in men and women and correlates of sexual dysfunction with psychosocial distress (Balon, Yeragani, Pohl & Ramesh, 1993; Laumann, Paik, & Rosen, 1999; Morokoff & Gillilland, 1993; Rosen, Taylor, Leiblum & Bachmann, 1993; Spector & Carey, 1990). They have illustrated that sexual counselling is both an important and a needed service. Despite this well-documented need, some students have received the indirect message during their graduate training that sexual counselling is unimportant, not prevalent or not needed. This finding is consistent with previous conclusions that "a subtle message about the peripheral importance (at best) or the taboo nature (at worst) of sexuality is being conveyed by the programs' inattention to sex education" (Nathan, 1986, p. 524). It is unlikely that such messages are intentional. It is difficult, if not impossible, to provide instruction on every area of potential concern in the field of counselling psychology. Many specific topics must be omitted in the interest of limited time, staff and resources. However, unlike other issues such as depression, anxiety or grief, clients may rarely comment on their sexual concerns without appropriate questions, permission and support initiated from their counselling psychologist. In order to take such initiative, student counsellors must themselves be comfortable. But, as the World Health Organization (1974) has described,

> Students in many parts of the world grow up in cultures that evade direct confrontation with sexuality; sex acts are private and secret, and are only referred to by indirect suggestion or by joking. They have no language which suits the subject and no practice in serious communication about it (p.19).

Such students quickly become newly practicing therapists at risk of providing poor service to clients with sexual concerns.

The majority of clients do not require specific sex therapy intervention, but basic support and education (Annon, 1976). Health Canada (1994) has described several standards for sexual health educators that could be considered equally important for counselling psychologists. These include 1) extensive general knowledge of human sexuality; 2) a comfort level sufficient to create rapport with people having diverse backgrounds and experiences and a capacity to respond confidently and respectfully to the sexual health education needs identified by specific groups; and 3) specific understanding of the issues surrounding sexual orientation and skill in providing effective education in this area. The results from this study can be used to inform curriculum development designed to increase graduate student knowledge and comfort with respect to counselling sexual issues, and improve services for clients with sexual concerns.

Recommended Guidelines for Curriculum Change

Sexual counselling curriculum needs to be consistently integrated into core courses. Counselling programs tend to offer sexual counselling education to its graduate students when there is a faculty member on permanent staff who has sexual counselling as an area of interest or specialization (Nathan, 1986; Wiederman & Sansone, 1999). Without the time or the staff to offer a whole course on counselling sexual issues, it is recommended that counselling programs establish required curriculum to be integrated into core counselling courses, and consistently deliver such curriculum regardless of the research or practice interests of the course instructor. This recommendation is consistent with the findings of this study, where 50% of respondents indicated that they would like material integrated into counselling courses and practicum courses.

Respondents also indicated an interest in having an optional 3-credit course or an optional training weekend regarding counselling sexual issues available. Despite student preference for optional involvement in elective courses or training weekends, instructors are encouraged to consider mandatory rather than optional training for students. This recommendation is related to the personality dimension of erotophobia/erotophilia. There is reason to be concerned about students who are more erotophobic than their classmates. Erotophobia has been linked to difficulty learning, talking or teaching about sexuality, and to the tendency to be more homophobic, and to avoid participation in elective sexuality seminars (Fisher, 1998; Fisher et al., 1988). Thus, those students who might benefit most from further education in this area may also be most likely to avoid participation, particularly if participation was merely optional.

In order to reach students who are more erotophobic, who have more negative feelings about sexual topics and erotic images, Fischer et al (1988) recommended that instructors avoid flooding students with explicit material, but rather gradually introduce material, beginning with that which is least explicit. When developing curriculum, counselling programs may wish to refer to literature regarding course content already established in some training programs for therapists (Buhrke & Douce, 1991; Freeman, 1989; Goldstein-Lohman & Aitken, 1995; Whitman, 1995) and allied health professionals (Duldt & Pokorny, 1999; Hay et al., 1996; Leiblum, 1995; Rosenzweig & Pearshall, 1978; Tepper, 1997).

Knowledge related to human sexuality can be enhanced through independent reading. An important result from this study was that those students who had read independently about human sexuality related topics were both more knowledgeable of human sexuality and more comfortable with sexual counselling scenarios. Based on this finding, it is suggested that students be assigned required readings to complete regarding sexual dysfunctions, sexual counselling techniques and other topics deemed relevant by counselling course instructors. Inclusion of articles regarding the sexuality issues of minority groups may be helpful, given that students were least comfortable with hypothetical counselling scenarios involving clients who were homosexual, elderly or disabled. The step of assigning readings alone would likely reduce or eliminate the message received by students from their counselling program that counselling sexual

issues is unimportant, without taking a lot of class time. Class time might then be better utilized practicing sexual counselling skills or discussing pertinent issues, rather than disseminating factual information.

Practical experiences need to be provided in order to increase comfort with sexual counselling. Student comfort when asked to imagine sexual counselling scenarios was positively related to total hours of counselling experience. Such comfort is important for providing competent service to clients. Without experiences that build comfort in the area of sexual counselling, clients seen during student practicums and during initial years of post-graduate counselling may receive poor service. Thus, curriculum needs to provide opportunities for students to gain experience. This might be achieved via role-playing in small groups and processing the feelings that such experiences evoke.

It is difficult for students to obtain experience with sexual counselling during their practicums, unless they begin asking their clients directly. The majority of graduate students from this sample were asking less than 10 percent of their clients about sexual concerns. This low frequency of asking may be related to a non-directive counselling approach. Simply encouraging students to begin including generic sexual history questions as a part of their initial interviews with clients, may also lead to opportunities where students can develop comfort and practice applying appropriate language about human sexuality during the counselling process.

Table 2-1
Mean comfort scores and percentage of low comfort responses for eight sexual counselling scenarios

Sexual Counselling Scenario	Mean Score	% Uncomfortable*
Male client with communication issue regarding fellatio	3.78	22.2
Heterosexual couple with sexual dysfunction	3.67	22.2
Attractive individual client, opposite sex	3.56	27.8
Teenager with masturbation questions	3.53	27.8
Gay male couple with sexual concerns	3.39	36.1
Depressed male client with paralysis from waist down	3.19	33.3
Lesbian couple with sexual concerns	3.00	41.7
70 year-old female with depression	2.69	55.6

*Uncomfortable students were defined as those who were either very or sort-of uncomfortable.

Table 2-2
The percentage of students who initiate questions with their clients about sexual concerns

Asks About Sexual Concerns	Percentage of Students (n)	Percentage of M.Ed. Students (n)	Percentage of Ph.D. Students (n)
With less than 10% of clients	65.7 (23)	80.0 (12)	55.0 (11)
With 10 to 40% of clients	14.3 (5)	13.3 (2)	15.0 (3)
With 41 to 60% of clients	8.6 (3)	6.7 (1)	10.5 (2)
With 61 to 90% of clients	5.7 (2)	0.0 (0)	10.5 (2)
With greater than 90% of clients	5.7 (2)	0.0 (0)	5.3 (1)

Table 2-3
Preferences for type of education in sexual counselling

Type of Education Offered	%Yes	%No
Mandatory 3-day training weekend	8	92
Optional 3-day training weekend	44	56
Mandatory 3-credit course	11	89
Optional 3-credit course	58	42
Integrated into courses via lecture	50	50
Integrated into courses via role-plays	50	50

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Chapter 3

Paper #2: Are Psychologists-in-Training Prepared to Address Sexual Issues? Are clients at risk?

Sexual issues are both relevant and prevalent in the field of counselling psychology (Balon, Yeragani, Pohl & Ramesh, 1993; Laumann, Paik, & Rosen, 1999; Morokoff & Gillilland, 1993; Rosen, Taylor, Leiblum & Bachmann, 1993; Spector & Carey, 1990). Despite this well documented truth, the education provided to psychologists-in-training with respect to sexual counselling has been inconsistent and inadequate (Freeman, 1989; Gray et al., 1989; Nathan, 1986; Wiederman & Sansone, 1999). Given the high needs of clients regarding sexual concerns, and the relative lack of attention given to this topic at the graduate training level, clients may be at risk of receiving poor service or experiencing unethical practice during counselling. Before interventions can be designed to address this problem, the problem itself must be better understood form the graduate student's perspective. To date, there appears to be no research that has investigated the educational needs of psychologists-in-training from the perspective of the student.

The current study was designed to address this gap in research regarding the preparedness of graduate student counsellors for sexual counselling. Several aspects of graduate student comfort, knowledge, disposition and behaviour considered relevant to the practice of sexual counselling were investigated.

Method

A convenience sample of students enrolled in a graduate counselling program from a Canadian university was studied. Thirty-six out of a possible 64 students responded to the distributed questionnaire (a 56% response rate). Of the 35 students who indicated their program level and gender, there were 15 master's-level, 20 doctoral-level, 28 female and 7 male students. Because the sample of male students was small, analysis of results was conducted for female participants only.

The "Sexual Counselling Survey," the questionnaire distributed, included several sections designed to address a number of constructs. The researcher newly developed all but one section for the purposes of this study. Sections I, V and VI contained questions regarding student demographic information and the amount of prior counselling experience. One multiple-choice question was also included in Section I regarding the frequency with which participants were asking their clients about sexual concerns. In Section VI, questions were included to determine the desire that graduate students had for education / training in the area of sexual counselling.

Section II involved a knowledge test of human sexuality. The test was created with items from undergraduate human sexuality textbook test-banks (Kelly, 1990; Rathus, Nevid & Fichner-Rathus, 1999). These items covered a number of topics including developmentally appropriate sexual behaviour, disability, homosexuality, unwanted sexual contact, sexual dysfunction and therapy techniques, and sexually transmitted disease. Item

analysis led to the omission of three items with poor discrimination values. Analyses were then conducted on a total of 17 items. The internal consistency of this knowledge test was 0.50. Given the number of distinct subject categories included, high internal consistency was not expected.

Student comfort in sexual counselling situations was addressed in Section III. Participants were presented with eight 5-point Likert scale questions regarding their comfort with hypothetical sexual counselling situations. An example of one such scenario is as follows: "A teenager begins to ask you questions about masturbation during a counselling session. How comfortable do you feel discussing masturbation with your client?" An internal consistency value of 0.89 was found for this comfort measure.

The Sexual Opinion Survey (Fischer, 1998) or S.O.S. was included in Section IV of the questionnaire. Twenty-one 7-point Likert scale items regarding the personality dimension of erotophobia-erotophilia are included in the S.O.S. This personality dimension involves the tendency for a person to respond to sexual ideas or content in negative to positive ways. S.O.S. scores ranging from 0 (most erotophobic) to 126 (most erotophilic) are possible. Internal consistency was in the .82 to .90 range from previous research (Fischer, Byrne, White & Kelley, 1998). In this current study, a Cronbach's alpha of .82 was calculated.

The Sexual Counselling Survey was distributed during classroom time or via mail. Participants were invited to complete the questionnaire independently and anonymously, returning completed surveys to sealed boxes. They were informed that results, if published, would appear either in group form or as unidentified quotations. Attempts to enhance the response rate were made by attaching a free coffee coupon to each questionnaire and by sending a follow-up electronic mail reminder to all students.

Results

Sexual Interviewing Behaviours of Students and Desire for Sexual Counselling Education

Twenty-seven female students responded to the question about interviewing clients regarding sexual concerns. Of these graduate students, 64.3% initiated questions regarding sexual concerns with less than 10% of their clients. When comparing master's and doctoral students, 76.9% of master's students versus 57.1% of doctoral students initiated questions regarding sexual concerns with less than 10% of their clients. Refer to Table 3-1 for a summary of results. Also, 100% of the participants indicated that they would like more education / training in the area of sexual counselling offered during their graduate program.

Knowledge of Human Sexuality

Students' total knowledge scores were normally distributed, with a mean score of 10.75 (SD = 2.00), a minimum score of 7.0 and a maximum score of 15.0. This test was not administered with samples from other populations, so it is difficult to draw comparisons regarding how knowledgeable this sample was. However, the following frequencies of incorrect responses to particular items may be of interest:

1) 79% of female students did not correctly identify the most common cause of sexual desire disorder, anxiety;
2) 43% of female respondents (n=28) did not indicate recognition of the term "sensate focus;"
3) 25% responded incorrectly to a question about the main route of transmission for HIV, choosing distracters such as blood / blood products, shared needles and homosexual sex; and
4) 25% chose incorrect distracters that cerebral palsy either causes infertility, decreases sexual desire, or impairs the ability to achieve orgasm, when the correct choice was that cerebral palsy limits coital positions.

Comfort with Sexual Counselling Scenarios

Students did not indicate the same comfort levels for each scenario, with responses ranging from very uncomfortable to very comfortable. For the means of students' comfort scores for each scenario, refer to Table 3-2. Included in Table 3-2 is the percentage of graduate students who were either very or somewhat uncomfortable with each scenario; between 21.4% and 64.3% of female students were uncomfortable, depending on the scenario. It was suspected that certain types of counselling situations were related to higher levels of discomfort. Therefore, the eight scenarios were divided into two groups: 1) heterosexual scenarios considered familiar to the majority of participants, and 2) minority group scenarios typically less familiar to participants (homosexual, disabled, teenager and geriatric scenarios). The mean of the average comfort scores for the group two scenarios (Mean = 2.85, SD = .93) was significantly lower than the mean of the average comfort scores for the group one scenarios (Mean = 3.53, SD = .93), as indicated by a paired sample t-test ($t = -5.75$, $p < .001$). Thus, students were least comfortable with scenarios involving the sexual issues of people from minority groups, people of different age, ability or sexual orientation.

Erotophilia and Relationship to Knowledge of Human Sexuality

In prior normative research on erotophilia (Fisher et al., 1988), results have been reported separately according to gender. Given that the sample of male subjects in this study was small, comparisons and analyses were made with female subjects only. The mean S.O.S. scores for a group of female Canadian undergraduate students in a sexuality course was 67.11 (SD = 18.59). For female participants in this study (n = 28), scores ranged from 40 to 113, with a mean score of 83.93 (SD = 15.03). The female graduate counselling students in this study were significantly more erotophilic than the normative comparison group ($t = 5.92$, $p < .01$). Another significant finding was that, for the female participants, erotophilia was positively correlated with knowledge of human sexuality ($r = .48$, $p < .05$).

Discussion

The Need for Competence in Sexual Counselling

Researchers have illustrated that a) the prevalence of sexual dysfunction for men, women, and couples is high; b) sexual dysfunction has implications of for marital

satisfaction and individual health; and c) sexual dysfunction coexists with other psychosocial issues for which clients present in counselling.

Sexual dysfunction prevalence. Sexual dysfunction is common for men, women and couples in North America. Sexual problems were found to exist in a national sample of men and women in the United States, in which 43% of women and 31% of men reported sexual problems (Laumann, Paik, & Rosen, 1999). Men and women experience different sexual issues, to varying degrees within a population. For women, 38% report problems with anxiety or inhibition during sex, 16% report a lack of sexual pleasure, 15% report difficulty achieving orgasm, 14% report decreased lubrication problems and 11% report painful intercourse (Rosen, Taylor, Leiblum & Bachmann, 1993). In a review article summarizing research spanning a 50-year period, Spector and Carey (1990) indicated that 4-9% of men report erectile dysfunction, 4-10% report inhibited male orgasm and 36-38% report premature ejaculation.

Difficulties experienced within relationships often both contribute to and result from such individual sexual issues as those listed above. The founders of sex therapy for couples, Masters and Johnson (1970), have estimated that 50% of American couples are affected by sexual dysfunction. A large number of such couples struggle with the complex issue of low sexual desire. LoPiccolo and Friedman found that for couples who attended sex therapy sessions, 32-55% presented with issues of low sexual desire (as cited in Spector & Carey, 1990).

Implication for marital satisfaction. The link between sexual satisfaction and marital satisfaction and happiness is well supported in the literature. Morokoff and Gillilland (1993) found that sexual satisfaction was correlated with marital satisfaction ($r = .55$ for men and $r = .41$ for women). Similarly, marital happiness has been found to correlate with sexual satisfaction (Perlman & Abramson, 1982). McCarthy (1982) once wrote, "when sex goes well, it's 15% of the marital relationship, and when it goes badly, it's 85%" (p. 11). Given the high prevalence of sexual issues with couples, and the demonstrated relationship between sexual and marital satisfaction, counselling psychologists need to be well prepared to address these issues in their practice.

Sexual dysfunction coexists with other problems for which clients seek counselling. Another important reason why counselling psychologists need to be prepared to address sexual concerns is that sexual dysfunction often coexists with other issues clients present with in counselling, or result from related medical treatments. A large number of clients have emotional or stress-related problems such as anxiety, depression, anger, grief, insomnia or chronic tension headaches. Laumann, Paik and Rosen (1999) found that "emotional and stress-related problems among women and men generate elevated risk of experiencing sexual difficulties in all phases of the sexual response cycle" (p. 534). Many of these emotional or stress-related problems result from either present or previous situations such as prior sexual abuse or unemployment. Laumann et al. (1999) found that "both female and male victims of unwanted sexual contact exhibit long-term changes in sexual functioning" (p. 544). For example, arousal disorder in women was found to be highly associated with sexual victimization, and male victims of adult-child contact were 3

times more likely to have erectile dysfunction and 2 times more likely to experience low sexual desire and premature ejaculation. Morokoff and Gillilland (1993) also found that erectile dysfunction is associated with unemployment in men.

Sexual dysfunction may also result from a medical treatment for a psychosocial issue, such as depression. Balon, Yeragani, Pohl and Ramesh (1993) have reported a high incidence of sexual dysfunction during antidepressant use (43%). These dysfunctions included "decreased libido, impaired ejaculation, inhibited orgasm, erectile dysfunction, and priapism" (p. 209).

The Risk of Poor Practice

Despite the well-documented need for sexual counselling services reviewed above, previous research has indicated that there is a lack of training being offered to graduate students in counselling sexual issues (Freeman, 1989; Gray et al., 1989; Nathan, 1986; Wiederman & Sansone, 1999). This lack of training may leave graduate student counsellors at risk of providing poor service to their clients.

Counselling students are neglecting to ask about sexual concerns. Unlike other issues such as depression, anxiety or grief, clients may be less likely to comment on their sexual concerns without appropriate questions, permission and support initiated from the counselling psychologist. Social taboos regarding the discussion of sexual matters, client discomfort with sex-related language, or lack of knowledge and education regarding human sexuality, may inhibit clients from expressing sexual concerns to their counsellors. For these reasons, it is incumbent upon therapists to initiate questions regarding sexual concerns with their clients. However, results from this study show that 64% of female graduate students from one Canadian University only ask questions about sexual concerns with less than 10% of their clients. Silence about sexual health may place clients at risk of poor service.

Discomfort may have a negative impact on counselling outcomes. Although research is limited regarding the phenomena of counsellor discomfort or anxiety, at least one study has illustrated that counsellor anxiety is correlated negatively with outcome ratings of counselling sessions (Kelly, Hall & Miller, 1989). In the current study, graduate student comfort ratings, when presented with a variety of sexual counselling scenarios, varied from very uncomfortable to very comfortable. At least 21% of the participants were uncomfortable with every scenario, with percentage of uncomfortable students ranging up to 64%, depending on the scenario. It is difficult to define standards for basic competence in this area of counselling. However, such discomfort would likely compromise client service and counselling outcomes (Kelly, Hall & Miller, 1989; Hayes & Gelso, 1993) with respect to counselling sexual issues.

Counselling students may respond inappropriately to sexual material. More serious than counsellor discomfort is the chance of sexual misconduct in response to sexual material discussed in counselling. This chance is real for practicing psychologists and likely for graduate student counsellors as well. Of 596 psychologists who responded to a

randomized national sample of practitioners from the American Psychological Association, 6% reported a sexual boundary violation with a client (Lamb & Catanzaro, 1998). Other studies from both the student and practitioner perspective have illustrated the need for improved sexual ethics training. Few psychologists believe they have received adequate training with respect to managing client-therapist sexual attraction (Pope, Keith-Spiegel, & Tabachnick, 1986). In addition, students surveyed from clinical psychology doctoral programs were found to lack knowledge of sexual ethics principles (Housman & Stake, 1999). The students from this study who demonstrated the best understanding had discussed client sexual attraction with a supervisor. Clearly, there is a need for training and supervision regarding this issue at the graduate level.

Counsellors who are not trained in dealing with client sexual material may be either inappropriately aroused by or avoidant of such topics in the counselling session. Schover (1981) conducted a study of male and female therapist responses to client sexual material, and found that "liberal" male therapists "were sexually aroused by, and verbally encouraged, the seductive female client" (p.477) while "conservative" male therapists were aroused by an audiotape of a female client describing a sexual dysfunction but "reacted with anxiety and verbal avoidance" (p.477). Graduate students in the present study demonstrated variable scores on the erotophobia – erotophilia continuum. There is the potential for concern with erotophobic counselling students. Researchers have found that erotophobic individuals find it more difficult to learn, talk or teach about sexuality, are more homophobic, and are less open to diverse sexual practices (Fisher, 1998; Fischer, Byrne, White & Kelley, 1998). Erotophilia can be a beneficial trait for counsellors who need to talk with their clients in an open and non-judgmental manner. Erotophilia has not been linked to sexual misconduct in the literature. Those psychologists who commit sexual boundary violations tend to be middle-aged men who also commit more non-sexual boundary crossings than other psychologists (Lamb & Catanzaro, 1998).

Diverse groups may be most as risk. The need for improved education of counsellors and health professionals regarding the sexual concerns of gay, lesbian and elderly clients is documented in the literature (Hayes & Gelso, 1993; Karlen & Moglia, 1995; Liddle, 1996) and has been supported by several results in this study. It was found that this sample of graduate student counsellors was less comfortable with scenarios involving the sexual issues of people who were from minority groups, including homosexual and disabled clients, than they were with heterosexual, able-bodied scenarios. They were also less comfortable with scenarios involving the sexual issues of clients outside of the graduate student age range, elderly and adolescent clients. Clients who present with diversities in age, sexual orientation or physical ability could then be viewed as most vulnerable to inadequate service from counsellors with respect to their sexual well being. Low S.O.S. scores for some of the participants in this study may mean that some students have a tendency towards homophobia or intolerance to a diversity of sexual practices. Given the positive correlation found between knowledge scores and S.O.S. scores, increasing student knowledge of human sexuality may increase erotophilia, improving acceptance of and positive feelings for people from diverse sexual backgrounds.

Poor knowledge of human sexuality may place clients at risk in other ways. Lack of knowledge can lead to assumptions, biases and misinformation given to those who require education. For example, 25% of female graduate students responded incorrectly regarding the main route of transmission for HIV, choosing distracters such as blood / blood products, shared needles and homosexual sex, and regarding the fact that cerebral palsy merely limits coital positions, 25% chose incorrect distracters that cerebral palsy causes infertility, decreases sexual desire, or impairs the ability to achieve orgasm. With such misinformation, therapists could make assumptions regarding the sexual orientation of an HIV positive client, or suggest to a married couple, where one individual has cerebral palsy, that infertility is likely.

Limitations and Implications

The possible implications for the results of this research are many. However, there were methodological weaknesses in the present study that need to be considered when drawing conclusions and implications. This sample was a convenience sample that was restricted to one Canadian University, and thus it is difficult to generalize findings to other programs. The number of male participants was also too small to make comparisons to female participants. It is recommended that future research expand on the present study, by administering the same or similar survey with a larger randomized national or international sample.

Despite limitations, the significance of these findings should not be ignored. Several groups and individuals are encouraged to take action to prepare Canadian counsellors, protect clients and promote competent service in the area of sexual counselling. It is recommended that:

1) In the interest of competent and ethical practice, licensing bodies review their standards for the education / qualification requirements expected of psychologists in the area of sexual counselling.

2) Professors and supervisors work together to develop or improve curriculum that directly addresses student concerns such as sexual counselling comfort, knowledge of human sexuality, and awareness of personal responses to sexual material. When developing such curriculum, instructors may wish to consider how student approaches to sexuality appear to exist on a continuum from erotophobia to erotophilia. Rather than trying to change the personality trait of erotophobia or erotophilia, it is suggested that instructors first attempt to increase student awareness of personal feelings and biases, normalize a broad spectrum of feelings, and encourage discussion and consultation.

3) Experienced practitioners in the area of sexual health education or sexual counselling offer their expertise to training programs to assist with the development and / or provision of improved education and preparation of psychologists-in-training.

Table 3-1:
The percentage of students who initiate questions with their clients about sexual concerns.

Asks About Sexual Concerns	Percentage of Students (n)	Percentage of M.Ed. Students (n)	Percentage of Ph.D. Students (n)
With less than 10 % of clients	64.3 (18)	76.9 (10)	57.1 (8)
With 10 to 40% of clients	17.9 (5)	15.4 (2)	21.4 (3)
With 41 to 60% of clients	7.1 (2)	7.7 (1)	7.1 (1)
With 61 to 90% of clients	0.0 (0)	0.0 (0)	0.0 (0)
With greater than 90% of clients	7.1 (2)	0.0 (0)	7.1 (1)

Table 3-2:
Mean comfort scores and percentage of low comfort responses for eight sexual counselling scenarios.

Sexual Counselling Scenario	**Mean Score**	**% of Students Uncomfortable***
Heterosexual couple with sexual dysfunction	3.64	21.4
Male client with issue regarding fellatio	3.61	25.0
Attractive individual client, opposite sex	3.36	32.1
Teenager with masturbation questions	3.32	35.7
Gay male couple with sexual concerns	3.32	35.7
Depressed male client with paraplegia	2.96	35.7
Lesbian couple with sexual concerns	2.68	53.6
70 year-old female with depression	2.50	64.3

*Uncomfortable students were defined as those who were either very or sort-of uncomfortable.

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Chapter 4

Paper #3: Sexual Problems? Breaking the Silence

If you have ever experienced a sexual problem or concern, you are not alone. There is a high prevalence of sexual dysfunction for women, men, and couples. Some sexual problems have a physical or medical cause, while many other sexual problems either result from or cause emotional issues. All can have a serious impact on relationship satisfaction and individual health. Talking about sexual concerns with a professional can be a crucial yet difficult step to take. Counsellors and medical professionals should initiate questions about your sexual health, but if they don't, speak-up. Self-advocate for your needs and break the silence around sexual issues.

In a recent, national sample of men and women in the United States, it was found that 43% of women and 31% of men reported sexual problems.[1] Included in the many problems women report are problems with anxiety or inhibition during sex (38% of women), lack of sexual pleasure (16% of women), difficulty achieving orgasm (15% of women), decreased lubrication (14% of women) and painful intercourse (11% of women).[2] Researchers Illana Spector and Dr. Michael Carey from Syracuse University found that the prevalence of commonly reported male sexual issues were: premature ejaculation (36-38%), male erectile dysfunction (4-9%), and inhibited male orgasm (4-10%).[3]

These individual sexual issues can either contribute to or result from difficulties experienced within relationships. Masters and Johnson, who are considered the founders of sex therapy for couples, have estimated that 50% of couples are affected by sexual dysfunction.[4] For those couples seeking sex therapy, 32-55% struggle with the complex issue of low sexual desire, where one or both partners have little or no sexual interest.[5]

For couples who <u>are not</u> experiencing sexual difficulties, the sexual aspect of their relationship may seem like a minor part of their overall relationship. However, for those who <u>are</u> experiencing sexual problems, sex can become a pronounced or major aspect of the relationship. Put more succinctly, a researcher once wrote that "when sex goes well, it's 15% of the marital relationship, and when it goes badly, it's 85%".[6] Research has demonstrated a strong link between sexual satisfaction and marital satisfaction or happiness.[7, 8]

Sexual dysfunction often coexists with other emotional issues, or results from related medical treatments. A large number of clients seen for counselling have emotional or stress-related problems such as anxiety, depression, anger, grief, insomnia or chronic tension headaches. Information was published in the Journal of the American Medical Association describing how "emotional and stress-related problems among women and men generate elevated risk of experiencing sexual difficulties in all phases of the sexual response cycle."[9] Some of these emotional or stress-related problems result from previous situations such as prior sexual abuse. Both female and male survivors of unwanted sexual contact often experience long-term changes in sexual functioning.[10]

Arousal disorder in women has been found to be highly associated with past sexual assault, and male survivors of adult-child contact were 3 times more likely to have erectile dysfunction and 2 times more likely to experience low sexual desire and premature ejaculation.

Sexual dysfunction may also be caused by a medical treatment for a psychosocial issue, such as depression or anxiety. Researchers have found that approximately 43% of patients taking antidepressant medication reported sexual dysfunctions such as decreased sexual desire, impaired ejaculation, inhibited orgasm, erectile problems, and painful orgasm.[11]

Clearly, if you are experiencing any concerns sexually, you are not alone. Counselling psychologists or medical professionals may be very helpful in resolving such concerns. But finding the courage and the words to express your concerns can be difficult. Most people in our western culture have not learned how to speak openly and seriously about sexuality and are more comfortable with joking or silence. Some may decide to wait until their doctor or counsellor asks them directly about their sex life. However, taking this approach might mean waiting too long.

Doctors and counsellors are typically well aware and prepared to assist individuals or couples with their sexual concerns, but may fail to ask the necessary questions. They too may be affected by social taboos and wish to protect your privacy or may simply assume that those patients with sexual problems will initiate the discussion. I found during my own graduate research that over half of doctoral students, in a counselling psychology program from a Canadian University, initiate questions about sexual concerns with less than 10% of their clients. Comments from some of these Ph.D. students were "…I don't always ask about it unless the client brings it up," and "I'm pretty non-directional in my counselling. If a client wants to talk about sexual issues, great!"[12]

We need to start talking, but waiting for your psychologist to make the first move could be a mistake. My advice? Speak-out and trust in the process. A small percentage of people with sexual concerns need to consult with a "sex therapist." Most people simply require support and education, skills which any chartered psychologist or physician should provide. When more specialized assistance is needed, they can suggest an appropriate referral.

A chartered psychologist is a counsellor who is registered with a provincial regulatory body or college (e.g. the College of Alberta Psychologists). Such a regulatory body ensures that psychologists have the appropriate educational qualifications and monitors competent and ethical practice of its registrants. Finding a counselling psychologist by flipping through the yellow pages can be an intimidating process. Other methods could include asking for a recommended name from a friend who has been for counselling, asking for a referral from your family doctor, or calling your provincial college of psychologists for suggestions. If payment for counselling is a concern, many counsellors offer a sliding fee scale, with lower fees for clients who have lower income.

Other people may be reimbursed for counselling via an extended health care plan, or may be covered by their company's confidential Employee Assistance Program (EAP).

For further information on a variety of sexuality-related topics, try starting with websites such as www.sexualhealth.com or www.passionatemarriage.com, while remaining cautious, as with all websites, of the information provided.

Notes

1. E. O. Laumann, A. Paik, and R. C. Rosen, "Sexual dysfunction in the United States," *Journal of the American Medical Association* 281 (1999): 537-544.

2. R. C. Rosen, J. F. Taylor, S. R. Leiblum et al., "Prevalence of sexual dysfunction in women: A survey study of 329 women in an outpatient gynecological clinic," *Journal of Sex & Marital Therapy* 19 (1993): 171-188.

3. P. Spector and M. P. Carey, "Incidence and prevalence of the sexual dysfunctions: A critical review of the empirical literature," *Archives of Sexual Behavior* 19 (1990): 389-408.

4. W. H. Masters and V. E. Johnson, *Human sexual inadequacy* (Boston: Little, Brown and Company, 1970).

5. P. Spector and M. P. Carey, "Incidence and prevalence of the sexual dysfunctions: A critical review of the empirical literature," *Archives of Sexual Behavior* 19 (1990): 389-408.

6. B. W. McCarthy, "Sexual dysfunctions and dissatisfactions among middle years couples," *Journal of Sex Education and Therapy* 8 (1982): 9-12.

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8. S. D. Perlman and P. R. Abramson, "Sexual satisfaction among married and cohabiting individuals," *Journal of Consulting and Clinical Psychology* 50 (1982): 458-460.

9. E. O. Laumann, A. Paik, and R. C. Rosen, "Sexual dysfunction in the United States," *Journal of the American Medical Association* 281 (1999): 537-544.

10. Ibid.

11. R. Balon, V. K. Yeragani, R. Pohl et al., "Sexual dysfunction during antidepressant treatment," *Journal of Clinical Psychiatry* 54 (1993): 209-212.

12. K. A. Jordan, "Graduate Training Needs in Sexual Counselling," *Unpublished master's thesis, University of Alberta, Edmonton, Alberta, Canada.*

Chapter 5 – Summary

Key research findings are briefly summarized in the following chapter, with reference made to the relevant papers for a more detailed discussion. The limitations of the study as well as implications for further research are also addressed.

Research Findings

Information was obtained with respect to the following research questions:

1. *How comfortable do graduate students feel about discussing sexual issues with their clients?*

Graduate student comfort with the written sexual counselling scenarios with which they were presented in the Sexual Counselling Survey varied. Individual responses ranged from very uncomfortable to very comfortable. Between one-fifth to one-half of graduate students were either very or somewhat uncomfortable with each scenario, depending on the scenario. Mean comfort scores with scenarios involving minority groups, such as people who are homosexual, disabled or elderly, were lower than the mean comfort scores for heterosexual scenarios (see Chapter 2 and 3 for detailed results and discussion).

2. *How knowledgeable are graduate students in various topics of human sexuality?*

The relative knowledge of graduate students in the area of human sexuality is difficult to judge from the information obtained from this survey. The frequency of correct responses to specific items did, however, give some indication that students may be lacking knowledge in areas such as sexual dysfunction, treatment for sexual dysfunction, sexually transmitted diseases and sexuality and disability (see Chapter 3 for discussion).

3. *How often are graduate-student counsellors asking their clients about whether or not they have sexual concerns?*

It was found that two-thirds of the graduate students surveyed initiated questions about sexual concerns with less than ten percent of their clients. These results were considered to be cause for concern and intervention (see Chapters 2 and 3 for discussion).

4. *To what extent do graduate students desire more training related to counselling sexual issues? What form of training is preferred?*

All of the graduate students surveyed stated a desire for more training to be available in their graduate program. More students preferred optional training than mandatory training. Also, half of the respondents endorsed integrating sexual counselling instruction into current courses (see Chapter 2 for discussion).

5. *How erotophilic / erotophobic are graduate students in counselling psychology?*

Compared to prior normative research, the female graduate students in this study were more erotophilic than two different samples of Canadian female undergraduate students (see Chapters 2 and 3 for discussion). Despite the high mean erotophilia for the females in this study, some individual scores were low or more erotophobic, possibly posing problems when counselling clients. The male graduate students in this study had higher mean erotophilia scores than the females, however this finding was not considered reliable given the small sample size of males.

6. *How much counselling experience do graduate students have?*

Counselling experience varied from less than one hundred hours to several thousand hours of time spent in direct counselling with clients, for the M.Ed. and Ph.D. students. The focus of the "counselling experience" results reported in this thesis were as they related to other constructs such as comfort (see Chapter 2).

7. *How much course-work or reading have graduate students completed with respect to human sexuality-related topics?*

Students reported a variety of background education in the area of human sexuality, from no prior coursework taken nor independent reading completed to several courses taken and independent reading completed. Again, the focus of these results were as they related to other constructs such as comfort and knowledge (see Chapter 2).

8. *Are there any significant correlations amongst the concepts investigated in the questions above (comfort, knowledge, desire for training, erotophilia, and experience)?*

Statistically significant positive relationships were found between:

- Degree of comfort with sexual counselling scenarios and amount of counselling experience
- Degree of comfort with sexual counselling scenarios and amount of independent reading about human sexuality
- Amount of human sexuality knowledge and amount of independent reading about human sexuality
- Degree of erotophilia and amount of counselling experience
- Degree of erotophilia and amount of human sexuality knowledge, for female participants

The above relationships were those reported and discussed in the preceding chapters. Other relationships were tested for but not found to be significant. For example, a moderate and positive but non-significant relationship was found between the degree of comfort with sexual counselling scenarios and amount of human sexuality knowledge ($r = .27$, $p = .12$). The probability that this relationship occurred by chance is expected to decrease with a larger sample size. Thus, a repeat study simply utilizing a larger sample

size might lead to more statistically significant correlations found between such constructs.

9. *During their graduate training, what level of support and kind of messages have graduate students perceived from interactions with instructors and supervisors, with respect to sexual counselling?*

Regarding support from instructors and supervisors, about two-thirds of those who responded to the relevant open-ended question stated that they had experienced little or no support. Also, the majority of respondents reported that they had either received no messages, messages of "silence," or messages that the area of counselling sexual issues was less important than other areas (see Chapter 2 for discussion).

Other Comments

The last question in the survey asked participants for any additional comments. The researcher found some indication from their comments that the act of completing the Sexual Counselling Survey itself may have increased awareness of the importance of training in the area of sexual counselling:

1. "This is definitely an area I need to work on due to my low level of comfort. My overall knowledge level is low too"
2. "From the m.c. questions, I feel like I have a lot to learn in this area"
3. "It made me realize how much people should review this material on a regular basis"
4. "This was a real eye-opener to fill in the questionnaire. I didn't realize I knew so very little"

Some participants also made comments that were supportive of the importance of sexual counselling training and research:

1. "We need much more training available to us; these are common counselling / couples issues"
2. "I think it's a topic that's easy to avoid but essential for well being"
3. "Important area to look at"
4. "It's funny that nobody has asked these questions before – I think that they are very important"

Student interest and support for this topic contributed to the researcher's enjoyment of the questionnaire distribution and collection process. Some students actually sought out the researcher and asked if they could complete the questionnaire. Many others, upon completion of the questionnaire wanted to know the answers to the knowledge questions. These answers were later sent to participants via electronic mail.

Study Limitations and Recommended Changes

There were several limitations inherent in the research methodology. Despite these limitations, the researcher has suggested several implications of significant findings for counselling psychology training and regulation in the area of sexual counselling (see Chapters 2 and 3). Awareness of the limitations leads to recommendations for future research, research that may serve to strengthen and broaden the findings of the current study.

Method

The generalizability of findings is threatened for several reasons. Firstly, it is limited by the small non-random convenience sample that was drawn from only one university counselling program. The sample size of males was also too small to make any conclusions about male graduate student characteristics, such as comfort, knowledge and erotophilia, as they might differ from female graduate student characteristics. Nonresponse to the survey also threatens generalizability. Forty-four percent of the accessible population surveyed did not respond. These individuals, amongst other possible reasons for nonresponse such as time restraints, may have been less comfortable with the area of sexual counselling or more erotophobic than those students who did respond to the questionnaire. These individuals may have also been less interested in receiving training in sexual counselling.

It is logical to suggest, however, that the graduate students in this study may be somewhat representative of other Canadian graduate students in counselling psychology with respect to the constructs in question. This is in part because it has been shown in the literature that insufficient training in sexual counselling is a common problem in graduate counsellor education. Thus, other Canadian graduate students may have experienced a similar absence of training in sexual counselling. In addition, although the sample was drawn from only one university, many students in this sample originate from other provinces across Canada. It is possible then that the sample was more representative of Canadian graduate students than if all the students attending the program surveyed had originated from the same province.

Another concern is the validity of the data obtained. Students were asked to complete questions regarding their sexual preferences and orientation as well as comfort with sexual content in counselling situations. Some students may not have been fully honest in their responses due to factors such as embarrassment, concern about the confidentiality of their responses, or the influence of responding in a socially desirable way. Participant confidence in the confidentiality of their responses may have been limited given that the researcher knew many of the participants and could have identified some of their anonymous questionnaires from demographic information.

Measure

The Sexual Counselling Survey was developed by the researcher for use in the current study (excluding the Sexual Opinion Survey section that was developed and used extensively in previous research). There are several ways in which this survey could be improved.

1. In section I, question 5, the wording should be changed such that participants are asked with what percentage of their adult clients they initiate questions regarding sexual concerns. A second question might also be added regarding questioning of adolescent clients.

2. In section II, the number of multiple choice knowledge test items could be increased significantly to approximately 100, with clusters of questions on specific topics, such that measures of internal consistency might be more meaningful.

3. In section VI, a question could be added asking participants what content they are most interested in learning about with respect to human sexuality / sexual counselling. For example, options might include topics such as the human sexual response cycle, sexual dysfunctions, treatment of sexual dysfunctions, sexuality and aging, sexual abuse, or sexuality and disability.

4. The Sexual Counselling Survey in its entirety or sections of it should be administered to normative groups. The significance of findings is difficult to judge without a normative sample with which to compare. For example, the knowledge test section could be administered to undergraduate students such that comparisons could be made to graduate student knowledge. Likewise, it would be interesting to have psychologists practicing in the community, with varying degrees of experience, complete the survey sections regarding comfort, knowledge, erotophobia and interviewing behaviors.

Future Research

The following are recommendations for future research, research that may serve to strengthen and broaden the findings of the current study.

1. Repeat the current study correcting for the limitations listed above as much as possible. Send the revised Sexual Counselling Survey to a random sample of graduate student classes in counselling psychology from multiple universities across Canada. Do so while avoiding the university from which the researcher originates to enhance participant confidence in the confidentiality of his or her responses. Also, attempt to have course instructors administer the questionnaire during class time to decrease the problem of nonresponse.

2. Send a similar survey to psychologists practicing in the community. Data from such research could be used for comparison when analyzing the knowledge or comfort levels of graduate students. It would be particularly interesting to ask such psychologists: a) whether or not they feel they were adequately prepared in graduate school to meet the sexual counselling needs of their clients, and b) what kind of graduate training would have been or was most beneficial.

3. Conduct related qualitative research including the client's perspective. For example, it might be interesting to do case studies of clients who are discussing sexual concerns with a graduate student counsellor. One could interview both the graduate student and the client regarding issues such as comfort, knowledge, perceived barriers to communication, and experience of the sexual counselling process.

Personal Reflections

My goal when commencing this research was to make a difference in the preparation of psychologists in sexual counselling, to illustrate that improvements need to be made in this area of counsellor education and make recommendations on how to do so. In order to further realize this goal, I will now begin to focus on publishing my results in academic and non-academic forms, and presenting the results at conferences.

In the process of discussing this research with faculty, fellow students, friends and family, I have increased somewhat my ability to speak comfortably and confidently about sexual topics. One day, I would like to be considered a skilled educator in the training of professionals to address the sexual health concerns of clients. Before I begin to lecture or train others in the area of sexual counselling, I must first seek training and gain experience in the area myself. I am aware of the importance of continuing education and look forward to opportunities through which I can strengthen my own comfort, knowledge and skills related to sexual counselling.

UNIVERSITY OF ALBERTA
FACULTY OF GRADUATE STUDIES AND RESEARCH
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

Sexual Counselling Survey

Your answers will remain completely confidential. In each section, you are asked to either circle the most appropriate response or write your answer in the space provided. Thank-you for your participation.

Section I:

The questions in this section are regarding your experiences with counselling clients in various areas of human sexuality, as well as your initial interview process.

1. Approximately how many clients have you counselled regarding sexual dysfunction issues?

Approximately ____ clients

2. Approximately how many clients have you counselled who were coping with issues related to a sexually transmitted disease?

Approximately ____ clients

3. Approximately how many clients have you counselled for whom issues of sexual identity were a concern?

Approximately ____ clients

4. Approximately how many clients have you counselled who were coping with issues related to unwanted sexual contact?

Approximately ____ clients

5. During your initial counselling interview(s), with approximately what percentage of your clients do you initiate questions about whether or not they have sexual concerns?

A. With more than 90% of my clients
B. With 61 to 90% of my clients
C. With 41 to 60% of my clients
D. With 10 to 40% of my clients
E. With less than 10% of my clients

Section II: Multiple Choice Sex Knowledge Items

Please circle the letter of the best single answer.

1. The two most common forms of childhood sex play are ____ and _____ .

A. oral-genital contact and simulated intercourse
B. self-manipulation and exhibition
C. self-manipulation and simulated intercourse
D. oral-genital contact and exhibition

2. Which of the following is possible for most men and women with paralysis of their pelvic regions?

A. penile erection in males but no vaginal lubrication in females
B. vaginal lubrication in females but no penile erection in males
C. both penile erection in males and vaginal lubrication in females
D. neither vaginal lubrication in females nor penile erection in males

3. Which of the following is a basic fact of masturbation?

A. masturbation is essential for physical and mental well-being
B. masturbation leads to homosexuality
C. masturbation hinders social development
D. masturbation increases knowledge of sexual feelings

4. In most studies the proportion of females who are homosexual is usually about ____ the number of males.

A. one-tenth
B. one-third
C. one-half
D. the same as

5. With respect to sex acts among homosexual men, it appears that ___ .

A. cunnilingus is more common than fellatio
B. anal intercourse is more common than fellatio
C. cunnilingus is more common than anal intercourse
D. fellatio is more common than anal intercourse

6. Nymphomania is to women as _____ is to men.

A. Klismaphilia
B. Infibulation
C. Satyriasis
D. Frotteurism

7. Among the common signs of previous sexual abuse of children are when a child attempts all of the following **except** ____ .

A. rape of another child
B. inserting objects into another child's rectum
C. coercing oral sex
D. self-manipulation of the genitals

8. The phase of sex therapy in which partners share pleasure without direct genital stimulation is called

A. sensory locus.
B. sensate focus.
C. sensual spiraling.
D. sensational circling.

9. At the present time, the most widely used approach in the treatment of sexual dysfunctions is directed to the modifications of

A. sexual behaviors.
B. sexual attitudes.
C. sexual values.
D. sexual feelings.

10. In terms of sexual responsiveness and performance, cerebral palsy

A. will limit coital positions.
B. causes infertility.
C. decreases sexual interest and desire.
D. impairs the ability to achieve orgasm.

11. Vaginismus is classified as a(n)

A. sexual arousal disorder
B. orgasmic disorder
C. sexual pain disorder
D. sexual desire disorder

12. The *most* common psychological cause of sexual desire disorder is

A. depression
B. anxiety
C. hypertension
D. shame

13. In men over 40, the incidence of sporadic erectile dysfunction is about

A. 5%
B. 25%
C. 50%
D. 80%

14. The best sex therapy techniques are of little benefit to couples

A. with unresolved conflicts
B. with organic sexual dysfunctions
C. with very different levels of sexual desire
D. that lack sexual knowledge

15. Deanna has never experiences an orgasm during intercourse but can achieve orgasm through masturbation. She is concerned that she has an orgasmic disorder. What should Deanna know?

A. She probably holds some deep-seated resentment toward her partner that needs to be resolved.
B. She is correct and probably does suffer from female orgasmic disorder.
C. Many women cannot achieve orgasm through coitus and require direct stimulation of the clitoris.
D. She probably suffers from guilt and sees sex as something shameful.

16. In treating sexual arousal disorders, one of the most important remedies is

A. concentration.
B. learning to use erotic fantasy.
C. learning new sexual techniques.
D. learning how to relax.

17. Worldwide, the main route of transmission for HIV is

A. heterosexual sex.
B. through blood and blood products.
C. through shared needles.
D. homosexual sex.

18. About 50% of the people infected with HIV in North America develop AIDS within

A. 2 years
B. 5 years
C. 10 years
D. 15 years

19. Which of the following individuals could be diagnosed with a paraphilia?

A. John: who exposes himself to women, feels compelled to do so, and feels distressed by his behavior.
B. Damon: who was arrested for distributing child pornography and sometimes watches videotapes of young children engaged in sexual acts.
C. Traci: who frequently fantasizes about using pain or humiliation with her sex partner.
D. Julio: who likes his wife to wear garter belts, stockings, and high-heeled shoes when they have sex.

20. A key component of the treatment process for rape survivors is to help the survivor

A. mobilize support
B. remember the details of the event
C. forgive the rapist
D. report the rape to the police

Section III:

In this section, please indicate how comfortable or uncomfortable you predict you would feel in the counselling situations described. Circle the number that best describes how you feel, where 1=very uncomfortable, 2=somewhat uncomfortable, 3=neither comfortable nor uncomfortable, 4=somewhat comfortable, and 5=very comfortable.

	Very Uncomfor table	Sort-of Uncom fortable	Neither Comf Nor Uncomf	Sort-of Com- fortable	Very Com fortable
1. A 70-year-old female comes to see you for counselling, with her main presenting issue being depression. How comfortable do you feel asking her if she has any sexual concerns?	1	2	3	4	5
2. An attractive individual client who is your same age but opposite sex states that he / she is experiencing sexual difficulties. How comfortable are you with interviewing him or her about the details of this sexual dysfunction?	1	2	3	4	5
3. On their third session of couple's counselling, a couple reveals that the man is experiencing erectile dysfunction and the woman is experiencing low sexual desire. How comfortable do you feel counselling them about their sexual relationship?	1	2	3	4	5
4. A gay male couple comes for counselling. One partner states he is upset that he is more often the recipient of penetration during anal intercourse. How comfortable do you feel counselling them regarding this issue?	1	2	3	4	5
5. A lesbian couple comes for counselling, stating that they have a number of relationship issues, including sexual difficulties. How comfortable do you feel counselling them about specific sexual practices, such as the use of sexual aids and toys?	1	2	3	4	5
6. A teenager begins to ask you questions about masturbation during a counselling session. How comfortable to you feel discussing masturbation with your client?	1	2	3	4	5
7. You are counselling a male client, who is paralysed from the waist down, regarding depression. How comfortable do you feel asking him about his sexuality?	1	2	3	4	5
8. You are counselling a male client who reports that his girlfriend keeps stroking his testicles during fellatio which causes him to lose his erection. He wants guidance on how to solve this problem. How comfortable do you feel?	1	2	3	4	5

Section IV: The Sexual Opinion Survey (S.O.S.)[1]

Please respond to each item as honestly as you can. There are no right or wrong answers, and your answers will be completely anonymous. Indicate the degree to which you agree with the statements below, where a 1 indicates that you strongly agree and a 7 indicates that you strongly disagree.

1. I think it would be very entertaining to look at hard-core erotica (sexually explicit books, movies, etc.).
   Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

2. Erotica is obviously filthy and people should not try to describe it as anything else.
   Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

3. Masturbation can be an exciting experience.

   Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

4. Swimming in the nude with a member of the opposite sex would be an exciting experience.
   Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

5. If I found that a close friend of mine was homosexual, it would annoy me.

   Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

6. If people thought that I was interested in oral sex, I would be embarrassed.

   Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

7. Engaging in group sex is an entertaining idea.

   Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

8. I personally find that thinking about engaging in sexual intercourse is arousing to me.
   Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

9. Seeing a pornographic movie would be sexually arousing to me.

   Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

10. Thoughts that I may have homosexual tendencies would not worry me at all.

    Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

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[1] The Sexual Opinion Survey, developed by William A. Fischer, as published in the Handbook of Sexuality Related Measures, 1998.

11. The idea of my being physically attracted to members of the same sex is not depressing.
Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

12. Almost all pornographic material is nauseating.

Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

13. It would be emotionally upsetting to me to see someone exposing themselves publicly.

Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

14. Watching a stripper of the opposite sex would not be very exciting.

Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

15. I would not enjoy seeing an erotic movie.

Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

16. When I think about pictures showing someone the same sex as myself masturbating, it nauseates me.
Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

17. The thought of engaging in unusual sex practices is highly arousing.

Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

18. Manipulating my genitals would probably be an arousing experience.

Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

19. I do not enjoy daydreaming about sexual matters.

Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

20. I am not curious about explicit erotica.

Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

21. The thought of having long-term sexual relations with more than one sex partner is not disgusting to me.
Strongly Agree 1 2 3 4 5 6 7 Strongly Disagree

Section V: Demographic Information

Please complete the following demographic questions, by circling your answer. Some of the demographic questions are listed as optional.

1. What is your gender? Female Male

2. In which program are you currently enrolled? M.Ed. Ph.D.

3. How old are you?(optional) 29 or under 30 or over

4. What is your sexual orientation? (optional) Heterosexual Homosexual Bisexual

5. Do you have any children? (optional) Yes No

6. Approximately how many hours have you spent in direct counselling (face to face counselling) with clients, as a part of both practicums and paid employment?

Example: Joe completed 200 counselling practicum hours during his M.Ed. degree and about 400 direct counselling hours during his internship. Joe has spent approximately 600 total hours in direct face-to face counselling.

_____ total hours

7. How many undergraduate courses regarding human sexuality have you taken?

0 1 2 3 or more

Please list the titles of course(s):_____
_____.

8. How many graduate courses have you taken where a substantial portion of the course was regarding human sexuality?

0 1 2 3 or more

Please list the titles of course(s):_____
_____.

9. Have you participated in continuing education coursework in human sexuality related topics?

Yes No

10. Have you spent time reading material to enhance your knowledge of human sexuality related topics?

Yes No

Section VI:

The following section includes questions regarding your opinions about current and potential curriculum in the area of counselling sexual issues.

1. I would like my graduate program to offer _____ education / training in the area of counselling sexual issues.

A. less
B. the same amount of
C. more

2. If more training / education regarding counselling sexual issues was introduced into your graduate counselling program, in what form(s) would you prefer this education take place? Choose as many options as you feel are appropriate.

A. A mandatory 3-day intensive training weekend.
B. An optional 3-day intensive training weekend.
C. A mandatory 3-credit course.
D. An optional 3-credit elective course.
E. Educational material integrated into all counselling course content, in lecture format.
F. Training integrated into all counselling practicum course content, via role-play exercises.

Other forms?_____.

Tell me the degree to which you have felt supported or encouraged by instructors or supervisors in the area of counselling sexual issues.

Comment on the message(s) you have received from your graduate program regarding the counselling of sexual issues.

What are the messages that you have received from society regarding the counselling sexual issues?

Tell me any additional comments that you may have regarding the topics included in this questionnaire.

Thank-you very much for your participation.

Kirsten Jordan (M.Ed. Student) Dr. Gretchen Hess (Supervisor)